#1. Q: We have the following concerns and questions. First, we have searched the TRICARE "Dual Eligibles" RFP site for "under age 65?" and the results were "0." To our knowledge, the CMS and DEERS data match has not been accomplished with the much needed ongoing monthly match. CHAMPUS records (dated late 1970's) acknowledge the need for this data match in order to properly identify and equally provide a personal letter notification to Medicare eligible's under age 65. Retired Medicare eligible beneficiaries under age 65 are included as part of the TRICARE FOR LIFE legislation -

A: The current CMS/DEERS data match does not include individuals under the age of 65 because contractually, the current Managed Care Support Contractors are only required to receive and process "crossover" claims for TRICARE For Life (TFL) beneficiaries, who are all aged 65 years or older. Prior to the enactment of TFL, there were insufficient numbers of patients with dual eligibility to justify the establishment of crossover agreements with Medicare carriers and Fiscal Intermediaries. Upon the implementation of the TDEFIC contract, the data match will be expanded to include the additional individuals who are under age 65. Please note that there is no RFP requirement to send letters to all under-65 matches identified. Instead, RFP paragraph C.3.11.2. only requires notification to go to households with past claims activity. Those households can be identified from the history files that will be furnished to the incoming TDEFIC contractor by the outgoing Managed Care Support contractor.

Q (a): Do the TDEFIC RFP requirements include these beneficiaries? And if so, where and how?

A: Yes. The TDEFIC RFP requirements include <u>all</u> persons, regardless of age, who have dual TRICARE/Medicare eligibility and who have received services within the 50 United States or the District of Columbia. As to "where and how," for claims processing purposes, dual eligibility will be determined from the DEERS response.

Q(b): It was our understanding these unique claims were being hand-processed by the current managed care contractors - do the requirements of the TDEFIC RFP include claims processing for ALL Medicare eligible beneficiaries?

A: Yes. Please see our response immediately above.

Q(c): How will these beneficiaries claims be processed if the DEERS/Medicare data match is not now in place?

A: Please see our responses above. The data match will be in place. TDEFIC claims will be processed by submitting an eligibility query to DEERS upon receipt of a claim, from whatever source. Dual eligibility will be determined from the DEERS response and appropriate disposition

action will follow, i.e., adjudication and payment or a disallowance based on lack of eligibility, non-coverage of services or other appropriate reason.

Q(d): Are these beneficiaries now automatically included with the "crossover" claims procedure from Medicare to Tricare?

A: The crossover claims agreements were negotiated by the current Managed Care Support Contractors directly with the individual Medicare carriers and intermediaries. TMA is not a party to those agreements and does not have copies of them. Therefore, we are unable to answer your question definitively. However, please note that the current CMS/DEERS data match does not contain dual eligibles under age 65. Therefore, we would not expect claims for these individuals to be included in the crossover claims transmissions unless the Managed Care Support Contractor has identified those additional dual eligibles to the Medicare Carriers and Fiscal Intermediaries in some fashion other than the data match.

Q(e): Over the course of the summer we are not aware that any new information on this category of beneficiaries has been published. A search of the CMS website for DEERS data match resulted in only finding information for data matches between DEERS and Medicaid.

A: Noted. If you are seeking a response to a specific query, please restate your question.

#2. Q: We have the following questions:

1. Is this project a new requirement or is there an incumbent contract?

2. If there is an incumbent -

   a. Who is the incumbent?
   b. What is the contract number?
   c. What is the approximate contract value?

A:

1. The TDEFIC solicitation is a follow-on to the continuing requirement for claims processing, customer service and administrative services such as the submission of payment records and workload reports to TMA. This requirement will take the place of the current practice of having each Managed Care Contractor (MCS) process claims for TRICARE/Medicare dual eligibles as a subset of their other TRICARE MCS responsibilities.

2.a. There is no single incumbent; all the current MCS contractors perform these functions. Please see the RFP, Section F, F-2.2, Contract Transition, for a list of the incumbent MCS contractors. Also, as stated above this requirement is only a component of the existing MCS contracts.

2.b. Please see response to 2.a.

2.c. Because this requirement is a component of the existing MCS contracts, we are unable to provide a contract value.

#3. Q: I visited the website but it stated the solicitation was not currently available. When will it be issued?

A: The solicitation was issued on 06 September 2002.

#4. Q: We would like to know if this contract can be managed out of State. We are in Virginia Beach, VA.

A: Yes, the contract can be managed and performed in any State or the District of Columbia.

#5. Q: Would it be possible to receive a copy of MDA906-02-R-0007 e-mailed to my attention?

A: The solicitation may be downloaded from the TDEFIC website. If there are difficulties in downloading any file, please go to the bottom of the TDEFIC web page to "Please Click Here to Request Technical Support" to request assistance.

#6. Q: I have registered as a potential offeror and was dismayed to learn that the solicitation is out and that I was not notified. Please advise if there is anything that I can do to ensure that I am advised of further changes. I am a consultant with clients who are interested in this procurement. I have to be kept advised as to status and your notification is not working as advertised. Any advice will be appreciated.

A: The RFP was issued on 06 September 2002. Potential offerors and other interested parties are advised that they are responsible for checking the TDEFIC website on a regular basis to keep apprised of any future actions such as amendments, notices, or Question and Answer responses. The Government will also send E-mail notification of such actions to firms and individuals registered as Potential Offerors but it is the responsibility of all interested parties to review the website on a regular basis. If any difficulties are experienced in downloading any files from the website, please go to the bottom of the webpage, were it is marked "Please Click Here for Technical Support," or e-mail the contracting officer.

#7. Q: C-1.1.1. states this solicitation is for beneficiaries eligible for both Medicare and TRICARE benefits for services received in the United States and the District of Columbia. We understand that claims for these beneficiaries incurred outside the United States is the jurisdiction for the successful bidder for the South Contract (reference to TMA RFP MDA906-R-0006, Managed Care Support) and this makes sense since Medicare does not pay for services in foreign locations. Could TMA please clarify who should process claims in US territories (Puerto Rico, Guam and US Virgin Islands) where Medicare does pay for services but for which the South Contractor processes regular TRICARE claims?

A: These claims will be the responsibility of the South Managed Care Support contractor resulting from RFP MDA906-02-0006.

#8. Q: TRICARE Operations Manual Chapter 22 Section 3, 1.0 states TRICARE is the last payer after Medicare and any other coverage. Will TMA please amend this to reflect the exceptions for Medicare and Indian Health coverage paying after TRICARE? This is critical considering there are cases where the TRICARE Dual Eligibility Fiscal Intermediary Contractor (TDEFIC) may need to reimburse state agencies that erroneously pay first and then find the patient is eligible for TRICARE Dual Eligible benefits. The TDEFIC must have the capability to reimburse state agencies in accordance with the requirement found elsewhere in the TRICARE Operations Manual and TRICARE Systems Manual.

A: We assume that in the second sentence you mean to refer to an exception for TRICARE paying before Medicaid rather than before Medicare. We do understand the intent and importance of your question. However, we do not believe we need to revise the language cited, because by definition in the Reimbursement Manual (Chapter 4, paragraphs I.A. and I.D.2.a.(2)) Medicaid and Indian Health Service treatment entitlement do not constitute other coverage.

#9. Q: TRICARE Operations Manual Chapter 22 Section 3, 6.1 says the TDEFIC must be able to know when a Managed Care Support Contractor (MCSC) has enrolled a provider to their network and when that network contract includes rates negotiated for dual eligible contractors. How will the TDEFIC be communicated these contract arrangements and negotiated rates? Will the MCSCs be required to share their negotiated rates?

A: Thank you for bringing this issue to our attention. A provider's network status should be identifiable from the "Provider Contract Affiliation Code" on the central provider record maintained by TMA. An alternative approach would be to ensure that as a part of the process of developing a Memorandum Of Understanding with each incoming T-Nex contract, the T-Nex contractors could include in the provider files that they share with the TDEFIC contractor an indicator as to whether a provider is network or non-network. However, we do not expect the T-Nex contractor to share with the TDEFIC contractor the specifics of their discount arrangements. The language you cite was inadvertently carried over from the previous TRICARE For Life instructions to the current Managed Care Support contractors. Therefore, we have initiated a change to the language of Chapter 22, Section 3, paragraph 6.1. to remove any reference to discount arrangements. An amendment to the RFP will be issued in the near future to incorporate this change.

#10. Q: TRICARE Operations Manual Chapter 22 Section 3, 4.1 and 4.2 indicates the level of audit to be conducted based on "government cost". Will this include combined Medicare and TRICARE liability or just TRICARE liability?

A: We assume you are referring to Chapter 22, Section 4 rather than Section 3. This language will be revised in Operations Manual Change 2 to clarify and revise the sample selection criteria. The reference to “government cost” will be replaced by language referring to the payment amount on the TED. An amendment to the RFP will be issued in the near future to incorporate this change.

#11. Q: H-2.5.1. of the RFP states the standard for Telephone Service Hold Time is 100% of all calls shall not be on hold for a period of more than 30 seconds during the entire call. TRICARE Operations Manual Chapter 1, Section 3.4 has two different requirements for hold time on telephones. The first requirement is that for calls transferred from an automated response unit (ARU), 95% must be answered within 30 seconds. The second requirement is the total “on hold” time for 95% of all calls not exceed 30 seconds during the entire telephone call.

Does the hold time in Section H-2.5.1 of the RFP encompass the hold time from the ARU and any hold time the caller may experience while talking to a Customer Service Representative? For example, a caller experiences 20 seconds on hold after being transferred out of the ARU to a Customer Service Representative. If a Customer Service representative puts the caller on hold for another 20 seconds to look up information, has the 30-second hold time been exceeded?

A: The language of H.2.5.1. will be changed to reflect the current Operations Manual standard, i.e., that total “on hold” time for 95% of all calls shall not exceed 30 seconds during the entire telephone call. The total time on hold does encompass all locations, but we believe the 95% standard vs. 100% is achievable.

#12. Q: We are trying to determine if this solicitation will include the processing of pharmacy claims. Pharmacy claims would include drugs, supplies, and durable medical equipment.

If this solicitation does not include the claims processing and customer support of pharmacy services for dual eligibles, will there be another solicitation released to satisfy that requirement?

A: This solicitation does not include processing of pharmacy claims. TRICARE Mail Order Pharmacy services have been acquired under solicitation MDA906-02-R-0002 and resulting contract number MDA906-02-C-0013. We expect a solicitation to be issued in the future for retail pharmacy claims processing. The specific categories of drugs, supplies and services to be covered will be defined in that solicitation.